AmeriHealth

Prior Authorization Form

Cesamet®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)* ☐ **Cesamet®** ☐ **Other (specify)** _____

Dose _____ *** Quantity** _____

Date: _____ Patient ID#: _____ DOB:_____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

*** Cesamet is limited to 6 units per prescription (specific to Medicare only)**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Chemotherapy-induced nausea and vomiting
☐ Other (specify)_____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

3. PATIENT HISTORY:

a. Has the patient tried and failed an ondansetron containing product (Zofran®)? ☐ Yes ☐ No
b. Has the patient tried and failed granisetron (Kytril®)? ☐ Yes ☐ No
c. Has the patient tried and failed aprepitant (Emend®)? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

_____

_____

_____

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only
Document #_____
M F Rx coverage Y N
Previous Auth Y N

Coverage effective date / /
Processor Initials_____ Date_____
STANDARD - SELECT LOB_____
Approved **Reviewer Initials**_____ Date_____